Suspicious Deaths

COUNTY OF SAN DIEGO ELDER DEATH REVIEW TEAM 2006 REPORT

COUNTY OF SAN DIEGO
AGING & INDEPENDENCE SERVICES
HEALTH AND HUMAN SERVICES AGENCY

County of San Diego
Office of the Medical Examiner

San Diego County
Sheriff's Department

San Diego County
District Attorney

County of San Diego

JEAN M. SHEPARD
DIRECTOR

PAMELA B. SMITH
DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
1700 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417

AGING & INDEPENDENCE SERVICES
9335 HAZARD WAY, SAN DIEGO, CALIFORNIA 92123-1222
(858) 495-5858 FAX (858) 495-5080

Aging and Independence Services
Director's Foreword

The County of San Diego Elder Death Review Team (EDRT) was established in March 2003, as a collaboration between the County of San Diego District Attorney; the County of San Diego Medical Examiner; the County of San Diego Sheriff; and the County of San Diego, Health and Human Services Agency, Aging and Independence Services.

Since its inception, the EDRT has been at the forefront reviewing suspicious elder deaths and making recommendations to prevent elder deaths that are a result of abuse and neglect in San Diego County. The EDRT has grown and flourished since its establishment. Partnership between member agencies has significantly increased and the collaboration between EDRT members has fostered an increased awareness of elder abuse issues among agencies that are involved in the identification, investigation and prosecution of elder abuse and elder deaths.

The members of the EDRT are committed, conscientious professionals who are passionate about reducing the incidence of elder abuse and share the common goal of decreasing the number of elder deaths in San Diego County that are a result of abuse or neglect. Their efforts have been recognized nationally by the American Bar Association Commission on Law and Aging, and their materials and experiences have been published in *Elder Abuse Fatality Review: A Replication Manual.*

As trailblazers in the review of suspicious elder deaths, the San Diego County EDRT has worked tirelessly to protect vulnerable elderly citizens in this county and educate others about elder abuse and neglect. I would like to thank them for their time, energy, attention, and dedication to this issue, and it is with great pride that I acknowledge the first report of San Diego County Elder Death Review Team.

Pamela B. Smith
Director, Aging and Independence Services

BONNIE M. DUMANIS
SAN DIEGO COUNTY DISTRICT ATTORNEY

November 7, 2005

San Diego County Elder Death Review Team
9335 Hazard Way
San Diego CA 92123

Dear San Diego County Elder Death Review Team:

The death of an older person is such a natural occurrence that it is altogether too easy to overlook, discount or rationalize away abuse as its root cause. With inquiry into the causality of suspicious deaths of older persons, there can be accountability and opportunity to prevent other such deaths.

I, along with others in county government, believe that through a multi-agency approach we can enhance the services which are so needed by our elderly population.

I am delighted that in March of 2003 my office, the Sheriff's Department, the Coroner, and the Health and Human Services agency joined forces to create the San Diego County Elder Death Review Team.

I am pleased by the progress that has been made and the fact that several recommendations have been implemented, including a procedure that allows the Coroner's Office to receive background information from Adult Protective Services.

I am grateful to the various team members for their participation in this vital service to our county. Hopefully, lessons can be learned from suspicious deaths of elders that can be used to strengthen existing collaborative efforts and provide even greater protection to the elder residents of San Diego County.

Sincerely,

BONNIE M. DUMANIS
District Attorney of San Diego County

BMD/sas

County of San Diego

GLENN N. WAGNER, D.O.
CHIEF MEDICAL EXAMINER

CHRISTINA STANLEY, M.D.
CHIEF DEPUTY MEDICAL EXAMINER

OFFICE OF THE MEDICAL EXAMINER
5555 OVERLAND AVE., SUITE 1411, SAN DIEGO, CALIFORNIA 92123-1270
TEL: (858) 694-2895 FAX: (858) 495-5956

TO: San Diego County
Elder Death Review Team
9335 Hazard Way
San Diego, CA 92123

Elder abuse in its many shapes and forms is increasingly recognized as a major problem for not only our county, but also the entire country. As the population grows and ages, it is a problem that can potentially impact all of us both professionally and personally.

It is reassuring to know that San Diego County is making the effort to examine elder deaths for potential abuse. In forming an Elder Death Review Team (EDRT) for the County of San Diego, the many agencies involved in the investigation of elder abuse and/or death have the opportunity to interact and exchange information.

Congratulations on your organization and the strides you, as a team, have made to analyze the deaths of elder abuse and neglect victims. Your strategies have led to increased awareness within the County government and in the community. The EDRT has led to increased communication between all involved agencies and increase awareness of the other agencies' roles. One example of this is the ability of Adult Protective Services to review the names of all elder deaths reported to the Medical Examiner's Office. The resulting information provided to our office may in turn impact our investigation of the death.

I am supportive and appreciative of the efforts that the EDRT of this County has displayed. Since the formation of the team in 2003, it has been a pioneer in the field of elder death review and a model for other jurisdictions. This report is a reflection of the hard work and dedication of the team members.

Sincerely,

Glenn Wagner, D.O.
Chief Medical Examiner

San Diego County Sheriff's Department

Post Office Box 939062 • San Diego, California 92193-9062

William B. Kolender, Sheriff

William D. Gore, Undersheriff

A MESSAGE FROM WILLIAM B. KOLENDER, SHERIFF

As the Sheriff of San Diego County, I am proud of my department's participation in the San Diego County's Elder Death Review Team. This team was officially formed in March of 2003, when county leaders recognized the need to form working partnerships to identify causes and potential gaps in services and to prevent elder abuse and neglect.

Since the team's inception, every effort has been made to ensure that suspicious deaths of elders do not go unexamined. Through the multi-agency approach, using the expertise within law enforcement, social services, medical organizations and community based groups; we can achieve enhanced protections and services required by our elder and dependent adult population. The residents of San Diego County are fortunate to have so many individuals and organizations that are committed to the wellbeing of our elderly population.

Sincerely,

Bill Kolender

William B. Kolender, Sheriff

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SAN DIEGO DISTRICT ATTORNEY

Acknowledgements

Our report was made possible through the support and efforts of the County of San Diego, Health and Human Services Agency, Aging & Independence Services.

We gratefully acknowledge the members of the County of San Diego Elder Death Review Team whose hard work and commitment to the goals of the team made this report possible. Although all members of the team reviewed the final draft of the report, a subcommittee of team members reviewed several drafts of the report and provided valuable input and recommendations. This subcommittee deserves special recognition for their time and outstanding efforts. The subcommittee members are as follows:

- Jennifer Bransford-Koons
  Program Manager, Adult Protective Services
- Vickie Molzen
  Program Manager, In-Home Supportive Services
- Ellen Schmeding
  Assistant Deputy Director, Aging & Independence Services
- Brenda Schmitthenner
  Administrative Analyst, Aging & Independence Services

Special thanks and recognition goes to Dawn Gibbons, Adult Protective Services Specialist, Aging & Independence Services, who compiled all the data from the investigative reports, analyzed the data, compared the data to current research and national statistics on elder abuse, and wrote this report. Without her diligence, expertise and time, this report would not have been possible.

Elder Death Review Team

Paul Greenwood, LL.B [Hons], Chair
Deputy District Attorney,
County of San Diego
District Attorney's Office,
Elder Abuse Prosecution Unit

Det. Leslie Albrecht
San Diego Police Department, Elder Abuse Unit

Terilyn Baracz
Administrative Analyst,
County of San Diego Health and Human Services Agency,
Vital Records

Det. Deborah Boyd
San Diego County Sheriff's Department,
Elder Abuse Unit

Jennifer Bransford-Koons
Program Manager,
County of San Diego Health and Human Services Agency,
Adult Protective Services

Sharon Cordice, LCSW
Program Manager,
County of San Diego Health and Human Services Agency

Terrance Corrigan
Assistant Public Administrator/Public Guardian,
County of San Diego Health and Human Services Agency

Daniela Davidian
Deputy City Attorney,
Office of the San Diego City Attorney, Elder Abuse Unit

Noelle Dorman
Congressional Aide, U.S. House of Representatives,
District 53, Congresswoman Susan Davis

Marco De La Toba
Supervising Public Administrator,
County of San Diego Health and Human Services Agency

Det. Suzanne Fiske
San Diego County Sheriff's Department, Elder Abuse Unit

Nancy Garcia-Drew, MSW
Supervisor,
County of San Diego Health and Human Services Agency,
Adult Protective Services

Dawn Gibbons, MSW
Adult Protective Services Specialist,
County of San Diego Health and Human Services Agency,
Adult Protective Services

Sgt. Nancy Kulinski
San Diego Police Department, Elder Abuse Unit

Membership Roster

Steve Magruder
Senior Deputy County Counsel,
County of San Diego Office of County Counsel

Chuck Matthews
Public Administrator/Public Guardian,
County of San Diego Health and Human Services Agency

Vickie Molzen
Program Manager,
County of San Diego Health and Human Services Agency,
In-Home Supportive Services Program

Susan Pollock
Ombudsman Program Coordinator,
County of San Diego Health and Human Services Agency

James Ramirez
Medical Examiner Investigator,
County of San Diego Medical Examiner's Office

Ellen Schmeding, MFT
Assistant Deputy Director,
County of San Diego Health and Human Services Agency,
Aging & Independence Services

David Smith
Senior Deputy County Counsel,
County of San Diego Office of County Counsel

Christopher Swalwell, MD
Deputy Medical Examiner,
County of San Diego Medical Examiner's Office

Myron Taylor
Regional Manager,
California Department of Social Services,
Community Care Licensing

Sherilyn Thurston, MSN, PHN
Public Health Nurse,
County of San Diego Health and Human Services Agency,
Adult Protective Services

Gary Tilinghast
Fire Prevention Specialist, City of San Diego

Sgt. Dave VanNyhuis
San Diego County Sheriff's Department
Elder Abuse Unit

Brenda Schmitthenner, MPA, Coordinator
Administrative Analyst,
County of San Diego
Health and Human Services Agency,
Aging & Independence Services

COUNTY OF SAN DIEGO
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DISTRICT ATTORNEY

Executive Summary

This is the first report of the San Diego County Elder Death Review Team (EDRT). The report encompasses information from the seventeen (17) suspicious deaths that were reviewed by the EDRT between May 2003 and November 2005. The two "vignettes" accompanying this summary are examples of the types of cases reviewed by the EDRT.

The Team

The EDRT is a multi-disciplinary team whose task is to review suspicious elder deaths occurring in San Diego County. The mission of the EDRT is to review deaths associated with suspected elder abuse and/or neglect, identify risk factors for such deaths, maintain statistical data concerning these deaths, and facilitate communication among agencies involved in the identification, investigation, or prosecution of elder abuse or elder deaths in order to bridge system gaps in service delivery. As its goal, the EDRT seeks to decrease the number of elder deaths in San Diego County that are a result of abuse, neglect or self-neglect and to identify the role of elder abuse and/or neglect as contributory factors in such deaths.

Accomplishments

The EDRT has accomplished numerous goals including greater team building among EDRT participants, increased awareness and sensitivity to elder abuse issues, and ongoing exchange of knowledge and information between EDRT members and participants. This ongoing exchange has resulted in collaboration between the County of San Diego's Adult Protective Services and the Medical Examiner's Office; and an innovative partnership between Adult Protective Services, the Medical Examiner's Office, and local hospitals.

Recommendations

The EDRT has identified several recommendations to concentrate on in the future. Such recommendations include continued meetings of EDRT, increased education to mandated reporters and first responders regarding elder neglect and abuse, and identification of legislative remedies that will support EDRT activities and goals.

The EDRT has been acting on the front line in addressing issues of elder abuse and preventing elder deaths in San Diego County. The members of the EDRT are committed, conscientious individuals who are passionate about issues of elder abuse and share the common goal of decreasing the number of elder deaths that are a result of abuse or neglect.

A Neglectful Daughter

Mary was an 87-year old widow whose husband of 65 years died two years prior to her death. Before his death, Mary's husband had been providing 24-hour care for her. After her husband's death, Mary's daughter, Laura, moved in with her. Throughout these two years, Adult Protective Services (APS) received numerous reports due to concerns that Laura was neglecting Mary's care. One week prior to Mary's death, APS received a report from a hospital social worker stating that when Mary was brought into the hospital, she was dehydrated, malnourished, had numerous severe bed sores, and facial bruising. Law enforcement then became involved because of the concerns that Laura had neglected and may have physically abused Mary. The Medical Examiner's office conducted an autopsy after Mary's death.

The Care Provider Who Provided for Herself

John was an 84-year old man who lived in his home. John needed assistance with tasks such as bathing, preparing meals, shopping, and transportation because of his multiple medical problems. John's son, who lived out of state, hired a care provider, Nancy, to live in and provide care for him. Several months later, APS began to receive reports from concerned neighbors and friends saying that Nancy was driving a brand new car. Soon after that, bank staff called APS to report suspicious banking activity on John's accounts. Upon investigating, the APS worker learned that John had added Nancy's name to the title of his house and his bank accounts. Three weeks after these changes were made, John was unexpectedly admitted to the hospital and died.

Mission

The mission statement, goals, and objectives of the EDRT were formalized in the Memorandum of Agreement between the County of San Diego District Attorney, Sheriff's Department, Medical Examiner, and the Health and Human Services Agency, Aging & Independence Services.

Mission Statement

It is the mission of the EDRT to:

Review suspicious deaths associated with suspected elder abuse and/or neglect.

Identify risk factors for such deaths.

Maintain statistical data concerning such deaths.

Facilitate communication among agencies involved with elder deaths in order to improve system gaps in delivery services.

Goals & Objectives

Goals

The goal of the EDRT is to decrease the number of deaths in San Diego County due to elder adult abuse as a result of physical abuse, neglect or self-neglect and to identify the role of elder abuse and/or neglect as contributory factors to such deaths.

The EDRT is a multi-disciplinary team whose task is to review elder deaths occurring in San Diego County in accordance with a pre-determined set of protocols and procedures. Information gathered by the EDRT and any recommendations made by the team are used to develop education, prevention, and if necessary, prosecution strategies that will lead to improved coordination of services for families and the elder population.

Objectives

The objectives of the EDRT are to:

- Promote changes in policies and procedures of governmental and private agencies to increase communication and cooperation, and to close service gaps.
- Improve the community response to those at risk.
- Evaluate services provided to victims and perpetrators prior to the death.
- Identify barriers to, and gaps in, services among service providers.
- Determine the circumstances surrounding suspicious deaths or deaths attributed to elder abuse or neglect.
- Provide information to public and private agencies that will increase their ability to identify and intervene with persons at risk.
- Increase public awareness of issues surrounding deaths due to family/caregiver violence.
- Have a positive impact on the safety and health of San Diego County residents.

It is estimated that for each case of elder abuse that is reported, as many as five other cases are not reported.

The Problem

Elder Abuse and Neglect

The United States Census Bureau estimates that there are more than 34 million adults age 65 and older living in the United States. Of that, an estimated 3.5 million older adults live in California, and 315,750 older adults reside in San Diego County (U.S. Census Bureau, Census 2000).

As the population of older adults continues to grow, so does the problem of elder abuse and neglect. Elder abuse is one of the fastest growing crimes in the United States. Over two million older Americans are the victims of abuse or neglect every year. The problem is compounded by the concern that elder abuse is grossly underreported. It is estimated that for each case of elder abuse that is reported, as many as five other cases are not reported (National Center on Elder Abuse, 1998). Cases of elder abuse resulting in death are also under recognized and underreported.

A Team Approach

Statewide

In February 2001, Senate Bill 333, Chapter 301, authorized all counties in the state of California to establish elder death review teams. This legislation states that elder death review teams can consist of experts in the field of forensic pathology; medical personnel with expertise in elder abuse and neglect; coroners and medical examiners; District and City attorneys; County staff including Adult Protective Services, Public Administrator, Public Guardian, Public Conservator, County health department staff, and County Counsel; law enforcement personnel; the office of the Long-Term Care Ombudsman; Community Care Licensing staff and investigators; geriatric mental health experts; criminologists; and representatives of local agencies that are involved in the oversight of Adult Protective Services.

Elder death review teams ensure that incidents of abuse and neglect involving victims who are 65 years of age or older are evaluated through interagency review of suspicious deaths. In the course of review, the involvement of each agency is examined. This aids in the development of recommendations for abuse prevention and intervention policies and protocols. Case review and examination also assists with developing legislative initiatives designed to reduce the incidence of elder abuse and neglect.

Locally

The County of San Diego Elder Death Review Team (EDRT) was established in March 2003 through a Memorandum of Agreement (MOA) between the County of San Diego District Attorney; the Medical Examiner; the County of San Diego Sheriff; and the County of San Diego, Health and Human Services Agency, Aging & Independence Services.

This is the first report of the EDRT since its establishment. The content of this report is based on information obtained since the first EDRT meeting in May 2003. A total of seventeen (17) suspicious deaths were reviewed by the EDRT between May 2003 and November 2005. The EDRT has made tremendous strides since its inception.

The need for the EDRT remains, as the incidence of elder abuse and neglect is increasing and continues to be underreported across the country. With improved service delivery, it is likely that the number of elder deaths in San Diego County from abuse and neglect will be reduced.

The EDRT aids in the development of recommendations for abuse prevention and intervention policies and protocols.

Was the victim's death intervenable at the individual, family, agency, or public policy level?

Case Review Process

The EDRT currently consists of 27 members. The EDRT convenes a minimum of once every two months to review the suspicious death of a victim aged 65 or older that was likely associated with elder abuse and/or neglect. One case is reviewed at each meeting. The EDRT Coordinator selects the case to be reviewed based on referrals from team members and member agencies. The EDRT Coordinator then collects information from all entities that had contact with the victim or the perpetrator and invites other agencies to attend EDRT meetings as appropriate.

Each EDRT member and invited participant signs a Confidentiality Statement (see Appendix A). All signed confidentiality statements are maintained by the EDRT Coordinator.

During each EDRT meeting a case review is conducted. The case review begins with a synopsis of the situation followed by the sharing of information from each attendee with relevant case information. The ERDT Coordinator completes the Case Review Investigative Report (see Appendix B) during the meeting based on case review information and with input from attendees.

The Investigative Report includes an investigative summary; information regarding the relationship between the victim and perpetrator; an assessment of risk factors associated with the perpetrator and the victim; and a determination as to whether the victim's death was intervenable at the individual, family, agency, or public policy level, not intervenable, or undetermined. Recommendations are also discussed and documented on the Investigative Report. Cases may be held over for continued discussion when necessary. The EDRT Coordinator maintains completed Investigative Reports.

Case Overview & Discussion

Seventeen cases were reviewed by the EDRT between May 2003 and November 2005. There were 19 perpetrators, as there were two perpetrators in two victims' cases.

Victim Demographics

- Sex of victims:
  - 13 (76%) were female
  - 4 (24%) were male.

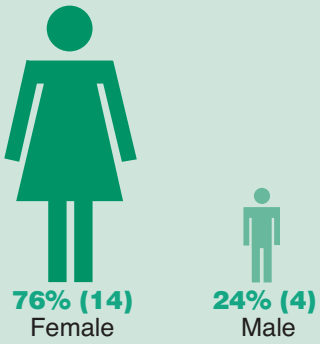
  The fact that the majority of victims have been female is consistent with data from the National Elder Abuse Incidence Study (National Center on Elder Abuse, 1998), the 2000 Survey of State Adult Protective Services (National Center on Elder Abuse, 2003), and the 2004 Survey of Adult Protective Services (National Center on Elder Abuse, 2006) all of which found that victims of elder abuse are predominantly women.
- Ethnicity of all victims:
  - 15 (88%) were Caucasian
  - 1 (6%) was African-American
  - 1 (6%) was Asian-American
- Ethnicity of female victims:
  - 12 (92%) Caucasian
  - 1 (8%) African-American
- Ethnicity of male victims:
  - 3 (75%) Caucasian
  - 1 (25%) Asian-American
- Area of county in which victim was living at time of death:
  - 8 (47%) were in North County
  - 3 (18%) were in Central San Diego County
  - 3 (18%) were in South Bay
  - 3 (18%) were in East County

Perpetrator Demographics

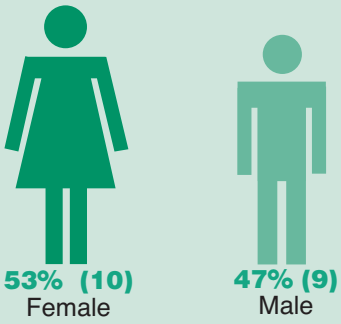
- Sex of perpetrators:
  - 10 (53%) were female
  - 9 (47%) were male

  This data is consistent with the 2004 Survey of Adult Protective Services which reported that "52.7% of alleged perpetrators of abuse were female" (National Center on Elder Abuse, 2006). However, this contradicts previous research in the area of elder abuse, which had shown that males were identified as perpetrators of abuse in the majority of cases (National Center on Elder Abuse, 1998; National Center on Elder Abuse, 2003).

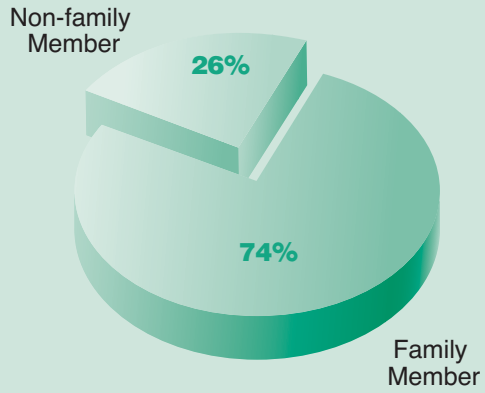
Sex of Victims



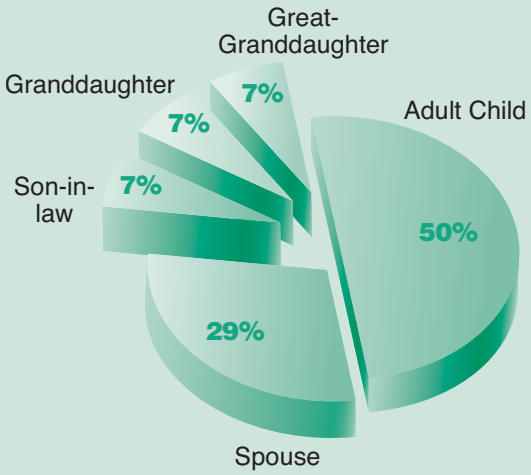
Sex of Perpetrators



Perpetrators' Relationship to Victims



Family Member Perpetrators' Relationship to Victims



- Perpetrator's relationship to the victims:
  - 14 (74%) family members
  - 5 (26%) non-family members

  The above finding is consistent with national statistics regarding elder abuse (National Center on Elder Abuse, 1998; National Center on Elder Abuse, 2003; National Center on Elder Abuse, 2006).
- Of the perpetrators who were family members:
  - 7 (50%) were adult children
  - 4 (29%) were spouses
  - 1 (7%) was a son-in-law
  - 1 (7%) was a granddaughter
  - 1 (7%) was a great-granddaughter

  When the specific familial relationships between perpetrators and victims are examined, adult children comprised the largest family group of perpetrators followed by spouses in the cases that have been reviewed by the EDRT thus far. This is consistent with the findings of the National Elder Abuse Incidence Study (National Center on Elder Abuse, 1998).

  However, the 2004 Survey of Adult Protective Services reported that "the most common relationships of victims to alleged perpetrators were adult child" followed by "other family members," unknown relationship, and then spouses/intimate partners (National Center on Elder Abuse, 2006).

  In contrast, the 2000 Survey of Adult Protective Services found that spouses/intimate partners comprised the largest group of perpetrators of abuse, followed by adult children (National Center on Elder Abuse, 2003).
- Of the perpetrators who were non-family members:
  - 2 (40%) were fiduciaries
  - 1 (20%) was a paid care provider
  - 1 (20%) was an unpaid care provider
  - 1 (20%) was a family friend

Risk Factors

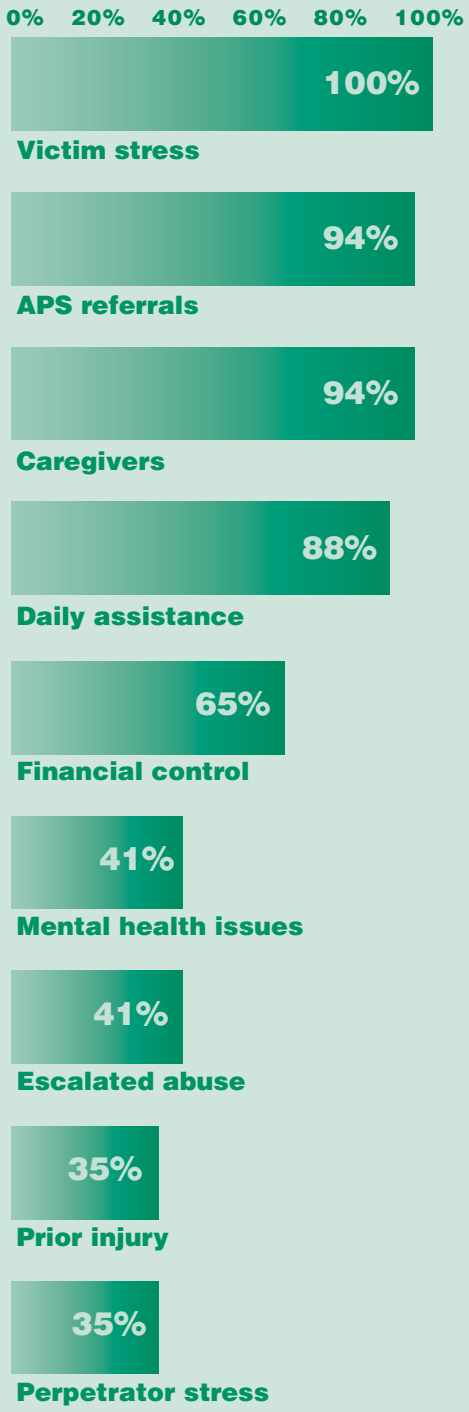
Risk factors are identified in the investigative report which is completed and maintained by the EDRT Coordinator.

- **Victim stress:** 100% of the victims experienced significant life stressors (e.g., recent death of a loved one, victim being moved out of his/her home, exacerbation of medical problems, declining health, etc.).
- **APS referrals:** 94% of the victims had been referred to Adult Protective Services (APS) at some time during their lives with an average of four abuse reports per victim.
- **Caregivers:** 94% of the perpetrators were acting in a caregiving capacity toward the victims.
- **Daily assistance:** 88% of the victims required assistance to complete activities of daily living (eating, bathing, dressing, grooming, toileting, mobility, transfers).
- **Financial control:** 65% of the perpetrators controlled the victims' finances.
- **Mental health issues:** 41% of the victims experienced mental health issues.
- **Escalated abuse:** 41% of the victims experienced an escalation of abuse prior to their deaths.
- **Prior injury:** 35% of the victims experienced injury in prior abusive incidents.
- **Perpetrator stress:** 35% of the perpetrators experienced significant life stressors (e.g., loss of job, chronic unemployment, financial problems, health problems, etc.).

In all of the cases that were reviewed by the EDRT, the perpetrators had a personal relationship with the victims, usually a familial relationship. All of the victims (100%) experienced significant life stressors. In addition, 88% of victims required at least some level assistance in order to complete activities of daily living (eating, bathing, dressing, grooming, toileting, mobility, transfers), and 41% of victims experienced mental health issues. All of this highlights the vulnerability of the elderly victims in these situations.

Most perpetrators were controlling the victims' finances (65%), and were acting in the capacity of a care provider to the victim (94%). This suggests that the perpetrators were in positions of trust and great responsibility, and the victims were frequently dependent on the perpetrators. This is consistent with research in the field of elder abuse.

Risk Factor Breakdown



Accomplishments

The Medical Examiner Review Team, a cooperative effort at improved communication between Adult Protective Services and the Medical Examiner's Office, is one of the first of its kind in California.

- Awareness
  There is an increased awareness and sensitivity to the issue of elder abuse among EDRT members and participants and the agencies they represent.
- Knowledge exchange
  There has been an ongoing exchange of knowledge and information between EDRT participants regarding each agency's role and systems.
- Team building
  There has been team building and increased collaboration between the members of EDRT and their member agencies.
- Commitment
  There is a sense of shared purpose between all agencies and parties involved in the EDRT.
- Training
  The Sheriff's Department's Elder Abuse Unit conducted training sessions with Sheriff's Deputies at the local stations to increase their understanding of the indicators of elder abuse and neglect and the elder abuse laws.
- Medical Examiner Review Team
  Upon the recommendation of the EDRT, a pilot project between the County of San Diego's Adult Protective Services and Medical Examiner's Office began in February 2005. This pilot project, referred to as the Medical Examiner Review Team (MERT), seeks to increase communication between Adult Protective Services and the Medical Examiner's Office related to decedents.

  MERT is comprised of staff from the County's Aging & Independence Services (AIS), the Medical Examiner's Office (ME), Adult Protective Service (APS), and the AIS Call Center. APS provides relevant case information to the ME's Office regarding decedents for whom the ME's Office plans to perform autopsies. APS is also available 24 hours per day for consultation with ME Investigators.

  In September 2005, MERT expanded in several ways. First, MERT began examining all elder deaths reported to the Medical Examiner's Office (ME) including those for whom the ME's Office waives jurisdiction. Second, MERT expanded to include the Ombudsman's office who reviews cases that are reported to the ME and tracks incidents and data. Third, MERT changed from a pilot project to an ongoing project.

- Hospital participation
  Upon the recommendation of EDRT and MERT participants, another pilot project began in November 2005. This project is a partnership between APS, ME, and a local hospital. The hospital contacts the ME if a patient for whom hospital staff filed an APS report of suspected abuse and/or neglect dies while in the hospital. ME staff then contact APS to obtain relevant information regarding the allegations of abuse and/or neglect. APS is available 24 hours per day for consultation with ME Investigators.

Recommendations

- Meetings
  The EDRT will continue to meet a minimum of once every two months, as the need to review cases continues to grow.
- Outreach and education
  Increase outreach and education to mandated reporters of elder abuse, especially first responders and emergency room/hospital personnel regarding signs of elder abuse and neglect.
- First responders
  Educate first responders about elder neglect and abuse and the need for them to contact law enforcement immediately when these situations are identified so that the crime scene can be preserved.
- Legislation
  Identify legislative remedies that would serve to support EDRT activities and goals.
- Partnerships
  Expand the partnership between APS, ME, and the local hospital to include all major hospital systems located within San Diego County.
- Forms revision
  Revise the Investigative Report form to be more applicable to elder death cases.
- Suicide
  Review cases involving elder suicide

Include all major hospitals in the APS and ME partnership so that all suspected abuse- and neglect-related deaths are reviewed.

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APPENDIX A

COUNTY OF SAN DIEGO
ELDER DEATH REVIEW TEAM (EDRT)

CONFIDENTIALITY STATEMENT

The purpose of the County of San Diego Elder Death Review Team (EDRT) is to conduct a full examination of suspicious deaths associated with suspected elder abuse and/or neglect. In order to assure a coordinated response that fully addresses all systemic concerns surrounding these fatality cases, the EDRT must have access to all existing records on each person's death. This includes social services reports, court documents, police records, autopsy reports, mental health records, education records, hospital or medical related data, and any other information that may have a bearing on the intimate relationship violence victim and his/her family.

With this purpose in mind, I the undersigned, as a representative of

_____

Agency's Name

agree that all information secured in this review meeting will remain confidential as required by Penal Code section 11174.7 and any other applicable state or federal law, and will not be used for reasons other than that which it is intended. No material will be taken from the meeting with case identifying information.

_____

Print Name

_____

Signature

_____

Date

_____

Witness

4/03

APPENDIX B

County of San Diego Elder Death Review Team
CASE REVIEW- INVESTIGATIVE REPORT

Review Date:

Case Closed ( )
Case Held Over ( ) DATE:

Victim's Name	DOB	Date/Time of Death	Type of Death	ME No.	Case No.

INVESTIGATIVE SUMMARY

I. Victim's Information:

II. Past Medical History:

III. Pre-existing Life Threatening Disease/ Condition:

IV. Toxicology Report:

V. Cause of Death:

VI. Suspect's Name:

VII. Suspect's DOB:

Risk Factors	< 12 mos. ago	> 12 mos. ago	Comments
1. Escalation of abuse prior to homicide	P V	P V	
2. Graphic threats to kill	P V	P V	
3. Homicidal Ideation	P V	P V	
4. Stalking history by perpetrator	Yes No	Yes No	
5. Injury in prior abusive incidents. (required medical treatment from hospital/emergency treatment)	P V	P V	
6. TRO placed on perpetrator by victim	Yes No	Yes No	
7. TRO placed on perpetrator by other person	Yes No	Yes No	
8. TRO violation by perpetrator	Yes No	Yes No	
9. History of TRO's against perpetrator	Yes No	Yes No	
10. TRO in effect at time of homicide			
11. Police involved with previous elder abuse incident.	P V	P V	
12. Prior APS referral (s)	P V	P V	
13. Other:			
WEAPONS			
14. Access to firearms or other weapons	P V	P V	
15. Use of weapons in prior incidents (arson included)	P V	P V	
16. Threats with weapons	P V	P V	

Victim's Name	DOB	Date/Time of Death	Type of Death	ME No.	Case No.

RELATIONSHIP OF VICTIM & PERPETRATOR
17. Relationship of Victim & Perpetrator: • Family Member: (specify) • Care Provider: (specify) • Stranger: • Other: (describe)

RELATIONSHIP DYNAMICS/CONTROL			
18. Controlling of daily activities	P V	P V	
19. Obsessive-possessive beliefs	P V	P V	
20. Perpetrator perceives he/she has been betrayed by victim	Yes No	Yes No	
21. Victim gives perpetrator an ultimatum	Yes No	Yes No	

MENTAL HEALTH & SUBSTANCE ABUSE			
Risk Factors	**< 12 mos. ago**	**> 12 mos. ago**	**Comments**
22. Victim drug abuse (circle all that apply)	Cocaine Crack Crystal Meth. Heroin Marijuana Other:	Cocaine Crack Crystal Meth. Heroin Marijuana Other:	
23. Perpetrator drug abuse (circle all that apply)	Cocaine Crack Crystal Meth. Heroin Marijuana Other:	Cocaine Crack Crystal Meth. Heroin Marijuana Other:	
24. Alcohol abuse	P V	P V	
25. Gambling abuse	P V	P V	
26. Mental health problems (i.e. depression in perpetrator or victim)	P V	P V	
27. Mental health diagnosis of victim: (describe)			
28. History of suicide threat(s), ideation(s)	P V	P V	
29. History of suicide attempt(s)	P V	P V	

OTHER VIOLENCE/ABUSE			
30. History of committing child abuse	P V	P V	
31. History of committing other types of violence	P V	P V	
32. History/threats of violence towards pet(s)	P V	P V	
33. Destruction of property	P V	P V	

OTHER ISSUES			
34. Prior criminal history	P V	P V	
35. Previous contact with protective services (e.g. shelters, transitional housing, mental health counseling, substance abuse treatment etc.)	P V	P V	
36. Perpetrator ordered to a court	Yes No	Yes No	

Victim's Name	DOB	Date/Time of Death	Type of Death	ME No.	Case No.

stressors (e.g. loss of job, financial problems, death of a family member/close friend, physical health problems)			
38. Victim experienced significant life stressors (e.g. loss of job, financial problems, death of a family member/close friend, physical health problems)	Yes No	Yes No	
39. Perpetrator involved in other suspicious death	Yes No	Yes No	
40. Perpetrator has prior employment as caregiver	Yes No	Yes No	
41. Ability of victim to complete ADL's	1 3 5		1= totally dependent on others 3= some assistance needed 5= totally independent
42. Victim's prescription medications: (describe)			
43. Victim resided in: • Own residence alone • Own residence w/ others (specify) • Residential Care Facility • Hospice • Other (describe)			
44. Perpetrator's residence: (describe)			
45. Control of victim's finances: • Victim • Family member • Other (describe)			

INTERVENABLE/NOT INTERVENABLE/UNDETERMINED STATUS

1. **Intervenable at the:** Individual/Family ( ) Agency Level ( ) Public Policy ( )
2. **Not Intervenable** _____

   (Given similar circumstances, no opportunity existed to intervene).

3. **Undetermined** _____

   (Unable to determine if intervention was possible based on the limited information available to the team).

4. **General Policy** _____

   (While not directly related to the findings of the case, policy recommendations were determined).

RECOMMENDATIONS

1.
2.
3.
4.
5.
6.

REVIEW STATUS

Case Closed ( ) Case Held Over ( )

1.
2.
3.
4.
5.
6.

WHO WAS INVOLVED	WHO SHOULD HAVE BEEN INVOLVED

DATE	OCCURRENCE

APPENDIX C

Elder Abuse Resources in San Diego County

Adult Protective Services: 800-510-2020 (if calling from San Diego County)
800-339-4661 (if calling from outside of County)

Aging & Independence Services: 800-510-2020 (if calling from San Diego County)
800-339-4661 (if calling from outside of County)
http://www.ais-sd.com

District Attorney's Office-Elder Abuse Prosecution Unit: 619-531-3245

Elder Abuse Councils

North County: 619-515-8596 or 760-754-3573 or 760-739-6115
Central San Diego County: 619-515-8596
East County: 619-515-8596 or 619-401-3770
South Bay: 619-515-8596

Family Justice Center: 619-533-3500

Fiduciary Abuse Specialist Team (FAST): 760-480-1030

Network of Care: http://www.sandiego.networkofcare.org/aging/home/index.cfm

North County Family Violence Prevention Center: 760-798-2835

Ombudsman: 800-640-4661

Public Guardian: 858-694-3500

San Diego Police Department-Elder Abuse Unit: 619-533-3500

Sheriff's Department-Elder Abuse Unit: 858-974-2322

COUNTY OF SAN DIEGO
SHERIFF
EUREKA
DISTRICT ATTORNEY